



Designated Examiner Source Book

APPENDIX C

Outpatient Commitment Forms

- OUTPATIENT COMMITMENT TREATMENT PLAN
- REPORT OF DESIGNATED EXAMINER FOR OUTPATIENT COMMITMENT
- ORDER OF OUTPATIENT COMMITMENT

**REGION ____ MENTAL HEALTH
OUTPATIENT COMMITMENT TREATMENT PLAN**

Patient Name _____ Phone _____

Address _____

County _____

Mental Health Service Provider responsible for the patient's treatment under the
commitment order _____
(Name)

(Address) (Phone)

In the interest of said patient the following treatment plan is based on the patient's prior history. There is a reasonable prospect that the patient's mental illness will respond to the treatment proposed in this plan. A more restrictive treatment will not be necessary unless the patient becomes a danger to him/herself or others or is deemed gravely disabled due to his/her mental illness. This treatment plan expires on _____.

The proposed patient **is / is not** a voluntary patient.

Specific conditions the patient is expected to follow:

Patient may be involuntarily medicated with the following medication:

Patient's medical status will be reviewed in the following manner:

Plan for monitoring compliance with the required conditions of treatment:

Signature of Patient / Date

Signature of Mental Health Provider / Date

IN THE DISTRICT COURT OF THE [] JUDICIAL DISTRICT
OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF []

MAGISTRATE DIVISION

In the Matter of the Outpatient Commitment)
of)
)
,)
)
)
Patient.)

CASE NO.


**REPORT OF DESIGNATED EXAMINER
FOR OUTPATIENT COMMITMENT**

*(to accompany the
Application/Petition for The Hearing
of a Person Believed to Have a
Mental Illness)*

Patient's _____

(Soc. Sec. No.) (DOB) (Address)

(Telephone #) (Next of Kin)

 _____, a Designated Examiner duly appointed by the
Director of the Department of Health and Welfare, have personally examined the proposed
patient within the last fourteen (14) days on:

Date of Interview


Location


Duration

_____	_____	_____
_____	_____	_____
_____	_____	_____

 proposed patient **refused / did not refuse** to submit to examination by this designated
examiner.

I am of the opinion that:

1.  proposed patient **has / does not have** a history of mental illness as
indicated by:

2.  a result of the progression of this illness, the proposed patient,
without treatment is: (check all that apply)

- ☐ likely to injure him/herself;
- ☐ likely to injure others;
- ☐ likely to suffer substantial mental or emotional deterioration;
- ☐ likely to become gravely disabled.

3. ☐ The proposed patient was previously hospitalized.
 Place: _____ Date: _____.

4. ☐ proposed patient **does lack** / **does not lack** the capacity to make informed decisions about treatment.

☐ The Designated Examiner's findings of the mental condition and recommendations of the proposed patient to the Court are as follows:

☐ The proposed patient has a treatment plan (see attached) that can be satisfied by outpatient services.

☐ There is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan without having to be involuntarily committed to an inpatient facility if the patient complies with the treatment requirements recommended to the court.

☐ The proposed patient has by history substantially failed to comply on one (1) or more occasions with the prescribed course of treatment outside the hospital.

☐ ☐ The proposed patient now refuses or lacks the capacity to make informed decisions about the necessity for continued treatment.

☐ ☐ The proposed patient **is** / **is not** appropriate to receive treatment in an outpatient commitment setting.

☐ IER findings and recommendations for the appropriateness of this patient to receive treatment in an outpatient commitment setting or in an inpatient facility include the following:

I DO HERE BY CERTIFY that the facts stated in this Certificate of Designated Examiner are based on my professional judgment.

DATED This _____ day of _____ (month), _____ (year).

 Designated Examiner

[Prosecutor]

[] COUNTY PROSECUTING ATTORNEY

[Prosecutor]

Deputy Prosecuting Attorney

[] Division

[Address]

[City], ID xxxxx

(208) [Telephone Number]

IN THE DISTRICT COURT OF THE [] JUDICIAL DISTRICT

OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF []

MAGISTRATES DIVISION

In the Matter of the Outpatient Commitment of

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Case No.

,

**ORDER OF OUTPATIENT
COMMITMENT**

Patient.

Proceedings for the outpatient commitment, care, and treatment of the above-named patient, alleged to have a mental illness pursuant to Idaho Code § 66-339B, have been initiated by a written application filed with this Court on the ____ day of _____, _____ ;

A hearing was ordered and held on the ____ day of _____, _____, the Honorable _____ presiding; with _____, Deputy [] County Prosecuting Attorney, appearing on behalf of the applicant; and _____, [] County Public Defender, attorney of record appearing on behalf of the patient, , in person;

And, after the receipt of all evidence presented at the aforementioned hearing, the Court found by clear and convincing evidence that:

1. The said patient has a mental illness and is in need of supervision, treatment, and care; and

2. The said patient's mental illness is classified as _____
_____; and

3. Has a prescribed course of treatment for this mental illness; and

4. Has failed to comply with a prescribed course of treatment on one (1) or more occasions outside an inpatient facility; and

5. Because of a deterioration resulting from the failure to comply with the prescribed course of treatment is likely to suffer substantial mental or emotional deterioration, or be likely to injure himself or others, or become gravely disabled due to mental illness;

6. The said patient **lacks/possesses** the capacity to make informed decisions about treatment and, as such, the conditions of the treatment plan **may/may not** deny the patient's right to refuse specific modes of treatment, including the nonconsensual delivery of prescribed medication pursuant to the applicable provisions of Idaho Code § 66-346 (c); and

7. The said patient **has / has not** failed to comply with a prescribed course of treatment on one (1) or more occasions outside an inpatient facility.

8. The name and address of the patient's attorney is:

9. The name and address of the patient's spouse, guardian, adult next of kin, or friend:

NOW, THEREFORE, IT IS HEREBY ORDERED that the said patient be committed on an outpatient basis, pursuant to Idaho Code § 66-339B, to the Idaho State Department of Health and Welfare for an indeterminate time period not to exceed one (1) year.

IT IS FURTHER ORDERED that the conditions of the treatment shall be specified, and a copy of that treatment plan shall be provided to the patient as soon as practical after the hearing

IT IS FURTHER ORDERED that the RMHA shall determine within twenty-four (24) hours the least restrictive available outpatient facility consistent with the needs of the patient and the treatment plan, and that the [_____] County Sheriff take said patient into custody and transport to an outpatient facility within seventy-two (72) hours of the hearing if so designated by the Director of the Idaho State Department of Health and Welfare.

IT IS FURTHER ORDERED that if the patient fails to comply with the requirements of this Order, law enforcement is authorized upon the request of the director of the outpatient facility, the physician or the RMHA to transport the patient to the designated outpatient treatment facility or the physician's office for the purpose of making reasonable efforts to obtain the patient's compliance with the requirements of this Order for up to one hour.

DATED this ____ day of _____, 1998.

MAGISTRATE